

STATE OF MISSISSIPPI

MISSISSIPPI STATE DEPARTMENT OF HEALTH
VITAL RECORDS

11648470

FILING DATE MAR 25 2015 **CERTIFICATE OF DEATH** **STATE FILE NUMBER** 123- 2015-056161

1. DECEDENT'S LEGAL NAME (First, Middle, Last) James Miller **2. SEX** Male **3a. HOUR OF DEATH** 12:09 p.m. **3b. DATE OF DEATH (Month, Day, Year)** March 3, 2015

4. RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
☐ White ☒ Black or African American ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Hawaiian ☐ Samoan ☐ Asian Indian ☐ Guamanian or Chamorro
☐ Other Asian (Specify) _____ ☐ Other Pacific Islander (Specify) _____

5a. AGE AT LAST BIRTHDAY 66 **ONLY IF UNDER 1 YEAR** **ONLY IF UNDER 1 DAY** **6. DATE OF BIRTH (Month, Day, Year)** [REDACTED], 1948 **7. BIRTH PLACE (State or Foreign Country)** MS

8. PLACE OF DEATH (Check only one box)
☐ DEATH OCCURRED IN A HOSPITAL ☒ DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL
☐ Inpatient ☒ Outpatient ☐ DOA ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify) _____

9a. FACILITY NAME (If not a facility, give street address, route number, or other location) University of MS Medical Center - 25U Jackson **9b. CITY, TOWN OR LOCATION OF DEATH** Jackson **9c. ZIP CODE** 39216 **9d. COUNTY OF DEATH** Hinds

10. DECEDENT'S EDUCATION - Check the box that best describes the highest degree or level of school completed at time of death.
☐ 8th grade or less ☐ 9th - 12th grade, no diploma ☒ High school graduate or GED completed ☐ Some college, no degree ☐ Associate degree (e.g., AA, AS) ☐ Bachelor's degree (e.g., BA, AB, BS)
☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) ☐ Unknown

11. MARITAL STATUS AT TIME OF DEATH
☒ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☐ Never married ☐ Unknown **12. SURVIVING SPOUSE (If wife, give maiden name)** Eddie Mae Mason **13. WAS DECEASED EVER IN U.S. ARMY?** Yes

14. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent is not Spanish/Hispanic/Latino.
☒ No, Not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino. (Specify) _____

15. SOCIAL SECURITY NUMBER [REDACTED]-5004 **16a. USUAL OCCUPATION (Kind of work done most of working life)** Commercial Sign Painter **16b. KIND OF BUSINESS OR INDUSTRY** Self Employed

17a. RESIDENCE - STATE MS **17b. COUNTY** Hinds **17c. CITY OR TOWN** Jackson **17d. ZIP CODE** 39209 **17e. STREET AND NUMBER OR RURAL LOCATION (Include apartment number)** [REDACTED] **17f. INSIDE CITY LIMITS (Yes or No)** yes

18. FATHER'S NAME (First, Middle, Last) Ezekiel Miller **19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)** Cora Mae Brown

20a. INFORMANT - NAME (Type or print) Eddie Mae Miller **20b. RELATIONSHIP TO DECEDENT** wife **20c. MAILING ADDRESS (Street and number, City or town, State, ZIP Code)** [REDACTED] St. Jackson, MS 39209

21a. DISPOSITION OF BODY (Specify: Burial, Cremation, Removal, etc.) Burial **21b. CEMETERY (CREMATORY) - NAME** Autumn Woods **21c. LOCATION (City and State)** Jackson MS **21d. FUNERAL DIRECTOR - STREET AND LICENSE NUMBER** [REDACTED] PE0055

22a. FUNERAL HOME (Who first assumed custody of body) Peoples Funeral Home 25P **22b. FUNERAL HOME LICENSE NUMBER** FE3 **22c. MAILING ADDRESS (street and number, city or town, State, ZIP Code)** P.O. Box 730 Jackson MS 39205

22a. FUNERAL HOME (If body was transferred prior to disposition) [REDACTED] **22c. MAILING ADDRESS (Street and number, City or town, State, ZIP Code)** [REDACTED]

23a. PERSON WHO PRONOUNCED DEATH - NAME AND TITLE (Type or print) Joe Pressler, MD **23b. PRONOUNCED DEAD (Month, Day, Year)** 3/3/2015 **23c. PRONOUNCED DEAD (Time)** 12:09 p.m.

24. NAME OF CERTIFYING PHYSICIAN OR CORONER (Type or print) Sharon Grisham-Stewart **24b. MAILING ADDRESS (Street and number, City or town, State, ZIP Code)** P.O. Box 1452 Jackson, MS 39215-1452

25a. To the best of my knowledge, death occurred due to the cause(s) and manner as stated.
25b. On the basis of examination and/or investigation, in my opinion, death occurred due to the cause(s) and manner as stated.
SIGNATURE Sharon Grisham-Stewart **25c. TITLE** CMEI **25d. DATE** 3/13/2015

26. CAUSE OF DEATH PART I - Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.
 IMMEDIATE CAUSE (final disease or condition resulting in death) → (a) Respiratory Failure
 (b) Swallowing difficulty
 (c) Parkinson's Disease
 (d) [REDACTED]

27. PART II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I. Hx of rectal cancer, hypertension, diabetes

28. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☒ No **29. IF FEMALE, ☐ NOT pregnant within the past year ☐ PREGNANT at the time of death ☐ Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF DEATH ☐ Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH ☐ Unknown if pregnant within the past year**

30. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify) **31. DATE OF INJURY (Month, Day, Year)** **32a. TIME OF INJURY** **32b. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED**

32c. IF TRANSPORTATION INJURY, SPECIFY
☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____

32d. INJURY AT WORK (Yes or No) **32e. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building, etc.)** **32f. LOCATION** Street or route number City or town State

Mississippi State Department of Health
THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE CERTIFICATE ON FILE IN THIS OFFICE

Form 511

5/7/2015

Judy Moulder
STATE REGISTRAR

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WARNING:

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ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

STATEMENT TO AMEND CAUSE OF DEATH

ATTACHED

APR 27 2015

THE DEATH CERTIFICATE OF James Miller, WHO DIED ON 03-03-2015 IN THE COUNTY OF Hinds ORIGINALLY CONTAINED THE FOLLOWING INFORMATION IN THE CAUSE-OF-DEATH SECTION.

ORIGINAL
(Do not write in this section)

26. CAUSE OF DEATH PART I - Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.				Interval between onset and death	
IMMEDIATE CAUSE (final disease or condition resulting in death)					
(a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):					
(b) <u>Swallowing difficulty</u> DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):					
(c) <u>Parkinsons Disease</u> DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):					
(d) _____ DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):					
27. PART II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I				28a. AUTOPSY (Yes or No)	
Hx of rectal cancer; hypertension; diabetes				No	
28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)				29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)	
				Yes	
30. DID TOBACCO USE CONTRIBUTE TO DEATH? (Yes or No)		31. IF FEMALE: <input type="checkbox"/> NOT pregnant within the past year <input type="checkbox"/> PREGNANT at the time of death <input type="checkbox"/> Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF DEATH			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH <input type="checkbox"/> Unknown if pregnant within the past year			
32a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify)		32b. DATE OF INJURY (Month, Day, Year)		32c. TIME OF INJURY	
32d. IF TRANSPORTATION INJURY, SPECIFY <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		32e. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED			
32f. INJURY AT WORK (Yes or No)		32g. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building etc.)		32h. LOCATION Street or route number City or town State	
NO		Home		4457 Bullard St. Jackson, MS	

THIS INFORMATION SHOULD NOW BE AMENDED TO READ AS FOLLOWS: FILL IN THIS ENTIRE SECTION AGAIN, EVEN IF ONLY ONE PART OF IT IS TO BE CHANGED OR AMENDED.

AMENDED SECTION

26. CAUSE OF DEATH PART I - Enter the chain of events - diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, shock, or heart failure without showing the etiology. List only one cause on each line. DO NOT USE ABBREVIATIONS.				Interval between onset and death	
IMMEDIATE CAUSE (final disease or condition resulting in death)					
(a) <u>Hypoxia</u> DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):					
(b) <u>Airway Obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):					
(c) <u>Food lodged in airway during eating</u> DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):					
(d) _____ DUE TO, OR AS A CONSEQUENCE OF (Enter one cause only):					
27. PART II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I				28a. AUTOPSY (Yes or No)	
History of Parkinson Dz., Rectal Cancer, HTN				No	
28b. AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH? (Yes or No)				29. WAS CASE REFERRED TO MEDICAL EXAMINER? (Yes or No)	
				Yes	
30. DID TOBACCO USE CONTRIBUTE TO DEATH? (Yes or No)		31. IF FEMALE: <input type="checkbox"/> NOT pregnant within the past year <input type="checkbox"/> PREGNANT at the time of death <input type="checkbox"/> Not pregnant, BUT PREGNANT WITHIN 42 DAYS OF DEATH			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Not pregnant, BUT PREGNANT 43 DAYS TO 1 YEAR BEFORE DEATH <input type="checkbox"/> Unknown if pregnant within the past year			
32a. ACCIDENT, SUICIDE, HOMICIDE, PENDING INVESTIGATION, OR UNDETERMINED (Specify)		32b. DATE OF INJURY (Month, Day, Year)		32c. TIME OF INJURY	
Accident		2/20/15		6:00p	
32d. IF TRANSPORTATION INJURY, SPECIFY <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) _____		32e. DESCRIBE HOW OR BY WHAT MEANS INJURY OCCURRED			
		Food lodged in airway during eating			
32f. INJURY AT WORK (Yes or No)		32g. PLACE OF INJURY (Specify Home, Farm, Street, Factory, Office building etc.)		32h. LOCATION Street or route number City or town State	
NO		Home		4457 Bullard St. Jackson, MS	

SIGNATURE AND TITLE

Sharon Grisham-Stewart
Sharon Grisham-Stewart; Hinds County CMEI

DATE SIGNED

4/22/15

MAR 27 2015

5/7/2015